### Rawlings Community Counseling



6807 Cody Street, Bonners Ferry, Idaho 83805

Phone: 208-267-0900 Fax: 208-267-6100

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Today’s date: PATIENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | | | | | | | | | | | | | | | | | | | ❑ Mr.  ❑ Mrs. | | ❑ Miss  ❑ Ms. | | | | | | | Marital status (circle one) | | | | | | | |
| First: | | | | | | | | | | | Middle: | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | | | | |
| Street Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City: | | | | | | | | | | | | | | | | State: | | | | | | | | | | ZIP Code: | | | | | | | Age: | |  | |
| Social Security no.: | | | | | | | | | | | | | | | | | | Birth date: / / | | | | | | | | | | | | | Sex: | | ❑ M | | ❑ F | |
| Email: | | | | | | | | | | | | | | Home phone no.: ( ) | | | | | | | | | | | | | | | Cell Phone No: ( ) | | | | | | | |
| Occupation: | | | | | | | | | | | | | | Employer: | | | | | | | | | | | | | | | Employer phone # ( ) | | | | | | | |
| Father: Phone number:  Mother: Phone number: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INSURANCE INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **(Please give your insurance card to the receptionist.)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Person responsible for bill:** | | | | | | | | | | | | | | | | | Birth date: / / | | | | | | | | | | | Home phone no.: ( ) | | | | | | | | |
| Address (if different): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is this person a patient here? | | ❑ Yes | | | | ❑ No | | Occupation: | | | | | | | | | | | | | | | | | | | | | | SS#: | | | | | | |
| **Employer**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | Employer phone no.: ( ) | | | | | | | | |
| Employer address: | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| **Is this patient covered by insurance**? | | | ❑ Yes | | | | ❑ No | | | | | ❑ Medicaid #: | | | | | | | | | | | | | | | ❑ Other | | | | | | | | | |
| Subscriber’s name: | | | |  | | | | | | | | | Birth date: / / | | | | | | | | | | | | | | | Co-payment: $ | | | | | | | | |
| Subscriber’s S.S. no.: | | | |  | | | | | | | | | Group no.: | | | | | | | | | | | | | | | Policy no.: | | | | | |  | | |
| **Name of secondary insurance (if applicable**): | | | | | | | | |  | | | | | | | | | | | | | | | Group no.: | | | | | | | | Policy no.: | | | | |
| Subscriber’s name: | | | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | |  | | | | |
| Patient’s relationship to subscriber: | | | | | ❑ Self | | | | | ❑ Spouse | | | | | | ❑ Child | | | ❑ Other | | | | |  | | | | | | | | | | | | |
| Total household size and income if requesting sliding fee discount program:  Proof of income required within 10 days of 1st visit:  Until proof of income is received all visits will be billed at full price: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Members of the household: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| |  | | --- | | Medical history | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Current Medications: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Current Diagnosis: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative (not living at same address): | | | | | | | | | | | | | | | Relationship to patient: | | | | | | | | Home phone no.: | | | | | | | | Work phone no.: | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | ( ) | | | | | | | | ( ) | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Rawlings Community Counseling. I understand that I am financially responsible for any balance. I also authorize RCC or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | |  | | | | | | | | | | |  |
|  | Patient/Guardian signature ( If Minor) | | | | | | | | | | | | | | | | | | | |  | | | | Date | | | | | | | | | | |  |